VFA-122 Dakota Incident Lessons Learned

Background:

On 27 October 2010, VFA-122 participated in a NAS Lemoore and Fresno City Fire Department Joint full-scale Class A Aircraft Mishap Exercise.

Scenario:

NAS Lemoore is executing normal flight operations and has one runway closed for ongoing repairs. The second runway becomes fouled by an aircraft experiencing a blown tire. NAS Lemoore Control Tower diverts all inbound aircraft to Fresno Yosemite International Air Terminal (KFAT).

An F-18 from VFA-122 is on a routine training mission within the NAS Lemoore Military Operating Area) MOA southwest of Fresno. The Pilot notifies KFAT Tower of an aircraft emergency. As the Pilot is on approach at approximately 2nm from KFAT, the aircraft experiences catastrophic failure of the left engine. Both aircrew eject safely and the aircraft impacts in the City of Fresno Palm Lakes Golf Course.

Response and On-site Training

Working with the Operations Department, it was agreed there would be no interruption to flight ops or schedule during the drill. We understand under normal conditions this would be exactly the opposite but accepted the decrease in training value to continue flight operations.

To keep training to a one-day evolution; first, members of the AMB (LCDR Bennett, LCDR Bell, and LT Baumeister) were onsite at the commencement of the drill in order to understand and witness the coordination of emergency response systems, second, the Emergency Reclamation Team was limited to 20 members from various Work Centers to provide training to those new team members and exposure to equipment required to investigate a mishap site properly. The NAS Lemoore Emergency Operations Center provided two Chief Petty Officers to assist in the training of recovery methods techniques, hazards and safety issues, etc. Total field training lasted approx 3 hours; unfortunately CMS had been collected too early to facilitate one aspect of intended training. Reclamation equipment was broken out and training on Tyvex suits, decontamination station, and investigation equipment was performed with the assistance of CWO3 Young, AMC Stucker, and CPO's from CNATTU/CSFWP.

Our squadron Flight surgeons and squadron Corpsmen were involved with the regional medical support team to assist with injured aircrew and answer any question pertinent to Naval Aviation Medical.

VFA-122 Objectives:

1. Exercise Mishap Response Plan:
   - The scenario had communication injects built in, to allow the reporting of the aircraft incident to be passed through multiple agencies, ultimately providing VFA-122 Operations Duty Officer (ODO) the necessary information required to initiate the CSFWP Mishap Response Plan. The communications inject lost traction at the Fresno Air Traffic Control Center, who failed to forward the information to the NAS Lemoore Duty Officer; ultimately the VFA-122 ODO was never informed.
   - **Lesson Learned:** The Operations Officer had scheduled a standby Duty Officer to orchestrate the Mishap Response Plan execution once notified, while the Operations Duty Officer could continue normal duties assigned. The VFA-122 Safety Officer should prepare a back-up means to broadcast the requisite information required to successfully exercise the Mishap Response Plan.
2. Exercise Joint Unified Command with the City of Fresno Emergency Management agencies.

- The City of Fresno Emergency Management agency's consisted of Fresno Fire department, Fresno Police and Emergency Ordnance Disposal, California Highway Patrol, American Ambulance Units, Local Red Cross, 144th Air National Guard Fire department.
- **Lessons Learned**: The Naval Safety Center provides Aviation Safety Officers a 3750 Mishap pocket checklist which is an extremely valuable tool in the field. But, these agencies listed provide a tremendous service to the investigating command. They are never mentioned in the 3750 checklist, or what they will initially provide to the Aviation Mishap Board or Squadron Safety Officer. Although their services don't necessarily assist the board in their findings, they most definitely will have the site secured prior to the AMB and ERT arrival, allowing for immediate investigation of the crash site. The Safety Officer will ultimately assume authority as Unified Incident Commander relieving the Emergency Management On-scene Commander and beginning the turn over process for military investigation and site security.

3. Exercise the Emergency Reclamation Team (ERT).
    a. Once notified, all work centers did not respond in a timely manner.
    - **Lesson Learned**: Sense of urgency being addressed with key leadership.
    b. Personnel departed for Fresno, with no accurate muster within Maintenance Control.
    - **Lesson Learned**: Senior khaki will provide muster prior to heading towards mishap site.
    c. NAS Lemoore Public Works policy for taking a vehicle off base is inefficient. Prior permission (trip ticket) requires advanced notice and can only be processed during normal business hours. Current vehicles assigned to VFA-122 do not support transportation of ERT/Mishap Kit.
    - **Lesson Learned**: Backfill Public Works that assigned vehicles went off base ISO emergency operations. If after hours, break down ERT/Mishap Kit and transport in smaller vehicles assigned (duty van / supply trucks).
    d. Based on the size and scope of operations within VFA-122, a traditional ERT is ineffective. Aircraft Division is developing a training plan to provide for a more robust ERT capacity within VFA-122.
    - **Lesson Learned**: Way forward is that all maintenance personnel will be required to meet established qualifications/training of an ERT to support multi-site operations.
    e. Current training/drills are focused on ERT aggressively initiating reclamation IAW prescribed procedures.
    - **Lesson Learned**: Training will include requirements within OPNAVINST 3750 for mishap procedures.
    f. ERT Kit lacks method to properly mark components found on the debris field/
    - **Lesson Learned**: Ordering small marking flags (four different colors).

4. NAS Lemoore Emergency Operations Center (EOC) VTC.
    a. The Commanding Officer was invited to attend the Video Teleconference between Joint Unified Command, NAS Lemoore EOC, and Navy Region South West Operations Center.
    - **Lessons Learned**: The Commanding Officer should remain at the squadron. The demand for support from the Crash Site can be organized and forwarded to the

appropriate departments while the CO receives updates from the Aviation Mishap Board. The VTC provides updates to local and regional leaders and broadcast future requirements the squadron is unable to provide at the site, second it provides a means to forward particular media interest and their findings to the local and regional Public Affair Offices.

In Summary, NAS Lemoore Emergency Operations Center provided a training opportunity for VFA-122 Safety Dept, Maintenance Dept, and City of Fresno Emergency Response Units. Squadron leadership withheld knowledge of and minimized any preparation, in order to afford the recently merged VFA-122/125 an opportunity to measure Mishap Response effectiveness while the squadron had 2 detachments deployed to NAS Key West and CVN-74. Safety Officers from local fleet squadrons took the opportunity to monitor the various phases of training presented and used it to better understand how complex an incident in city limits can become. These lessons learned have been submitted by each department and corrections to any deficiencies are in process.